



# BUREAU OF KIDNEY HEALTH CARE – APPLICATION FOR BENEFITS

Texas Department of Health Y-950 1100 W. 49<sup>th</sup> Street, Austin, Texas 78756

Phone 512-834-4551 Toll-free 1-800-222-3986

**Name of Applicant:**

Last \_\_\_\_\_

First \_\_\_\_\_

Middle \_\_\_\_\_ Suffix \_\_\_\_\_

(Jr., Sr., I, II)

**SSN:**

\_\_\_\_\_

**KHC Use Only**

KHC Patient Number:

**800**

## ADDRESS

Does applicant reside in a Nursing Home? ☐ Yes ☐ No

**Home Address**

Street (Physical Location)

Zip Code

City

State

Home Phone ( )

Work Phone ( )

Is Mailing Address same as Home Address? ☐ Yes ☐ No

If no,  
**Mailing Address**

P.O. Box/Street

Zip Code

City

State

Address correspondence **In Care Of:**

## APPLICANT INFORMATION

Do you have coverage other than Medicare or Medicaid? ☐ Yes ☐ No

Are you a Texas Resident? ☐ Yes ☐ No Date you became a Texas Resident:

Applicant is:  
(Optional)

☐ U.S. Citizen

☐ U.S. Non-Citizen National

☐ Qualified Alien (usually permanent resident alien or refugee)

Preferred Language: ☐ English ☐ Spanish

Date of Birth:

Gender: ☐ Male ☐ Female

SSN Document  
enclosed:

☐ Medicaid Card (Medicare # -in applicant's own SSN- must be imprinted on card)

☐ Medicare Card

☐ SSA Document

☐ Social Security Card

## RESIDENCY DOCUMENTS - List two (see Residency Documents list on page 2 of Application Instructions)

1) Document:

Date and/or expiration date:

Contains Texas address of applicant ☐ Yes ☐ No

Name on document ☐ Applicant ☐ Relation

**If Relation**

Name:

☐ Adult Child ☐ Guardian ☐ Other ☐ Parent ☐ Spouse

Supporting document:

2) Document:

Date and/or expiration date:

Contains Texas address of applicant ☐ Yes ☐ No

Name on document ☐ Applicant ☐ Relation

**If Relation**

Name:

☐ Adult Child ☐ Guardian ☐ Other ☐ Parent ☐ Spouse

Supporting document:

<b>FACILITY INFORMATION</b>			
Facility Name:		Facility Medicare #:	
Date Started at this Facility:		RTM:	
<b>Person Preparing Application</b>	Name:		
	Phone:		Fax:
	E-Mail:		
	Is Social Worker same as Person Preparing Application <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If no, Social Worker</b>	Name:		
	E-Mail:		
Is patient being transferred to another facility <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Transfer Facility</b>	Name:		Facility Medicare #:
	City:	Date of transfer:	RTM:
<b>FINANCIAL/TAX INFORMATION</b>			
<b>Taxable Income</b>	Estimated current year income: \$		Year:
	Or: Adjusted Gross Income: \$		Year:
Income Tax Return Enclosed: <input type="checkbox"/> Yes <input type="checkbox"/> No   Other Income Verification Enclosed: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Responsible Person</b>	<input type="checkbox"/> Applicant		
	<input type="checkbox"/> Other - Name:		Relationship:
Did applicant (or Responsible Person) file IRS return for previous year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, why: <input type="checkbox"/> Not required – Income under IRS limit			Number of Dependents: (excluding applicant)
<input type="checkbox"/> Not required – SS income only			
<input type="checkbox"/> Other			
<b>MEDICARE/MEDICAID</b>			
<b>Medicare Part A Status</b>	<input type="checkbox"/> Applied* - Date _____		Medicare Number:
	<input type="checkbox"/> Approved - Date _____		
	<input type="checkbox"/> Denied - Reason:	<input type="checkbox"/> Lack of Work Quarters <input type="checkbox"/> Residency Requirement Not Met <input type="checkbox"/> Alien Status <input type="checkbox"/> Did Not Pay Social Security Taxes	
	<input type="checkbox"/> Did Not Apply – Reason:	<input type="checkbox"/> Group Insurance Primary <input type="checkbox"/> CHAMPUS <input type="checkbox"/> Alien Status <input type="checkbox"/> Other	
<b>Medicare Part B Status</b>	<input type="checkbox"/> Applied* - Date _____		Medicare Number:
	<input type="checkbox"/> Approved - Date _____		
	<input type="checkbox"/> Denied – Reason:	<input type="checkbox"/> Lack of Work Quarters <input type="checkbox"/> Residency Requirement Not Met <input type="checkbox"/> Alien Status <input type="checkbox"/> Did Not Pay Social Security Taxes	
	<input type="checkbox"/> Did Not Apply – Reason:	<input type="checkbox"/> Group Insurance Primary <input type="checkbox"/> CHAMPUS <input type="checkbox"/> Alien Status <input type="checkbox"/> Other	
<b>Medicaid Status</b>	<input type="checkbox"/> Applied* - Date Referred to SSA/DHS: _____		Medicaid Number:
	<input type="checkbox"/> Approved - Date _____		
	<input type="checkbox"/> Denied - Reason: <input type="checkbox"/> Income <input type="checkbox"/> Alien Status <input type="checkbox"/> Other		
	<input type="checkbox"/> Did Not Apply - Reason: <input type="checkbox"/> Income <input type="checkbox"/> Alien Status <input type="checkbox"/> Refused <input type="checkbox"/> Other		
<small>*A recipient may have all KHC benefits modified, suspended or terminated for failure to apply for medical, drug, and transportation benefits under Title XIX, Social Security Act (Medicaid), if the applicant meets income &amp; other eligibility requirements for Medicaid. A recipient may have a portion of their KHC benefits modified, suspended or terminated, or claim(s) denied for failure to apply for benefits under Title XVIII, Social Security Act (Medicare).  <b>[KHC Rules Section 61.2(b)(4) and Section 61.2(d)(3)]</b> </small>			

<b>INSURANCE INFORMATION</b>				
<b>Type of Policy</b>	<input type="checkbox"/> Other <input type="checkbox"/> Group <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Government <input type="checkbox"/> Individual <input type="checkbox"/> Medicare Supplement			
<b>Insurance Company</b>	Name: _____			
	Phone: (       ) _____		Effective date: _____	
	Address: _____			
	Policy/ID#: _____		Group Name: _____	
	Group #: _____		Term. Date: _____	
	Zip Code: _____		City: _____ State: _____	
<b>Insured Person</b>		Insured's Name: _____		
		Insured's SSN: _____		
<b>Pre-Existing ESRD Condition:</b> <input type="checkbox"/> None <input type="checkbox"/> Temporary - End Date _____ <input type="checkbox"/> Permanent				
PPO/HMO : <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Visit Copay \$ _____	Other Outpatient Coverage % _____	Inpatient Coverage % _____	Deductible \$ _____
<b>Drug Coverage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Generic Benefit:                      Coverage:                      %                      Copay: \$ _____			
	Brand Benefit:                      Coverage:                      %                      Copay: \$ _____			
	Calendar Year Max:                      Other Max:                      Deductible: \$ _____			
<b>Major Medical or Indemnity Coverage:</b> Outpatient:                      %    Inpatient:                      %    Deductible: \$ _____				

### Disclosure of Social Security Number

A copy of the applicants personal Social Security card (or allowable substitute) which identifies the applicant's Social Security Number (SSN) is a mandatory requirement for a complete application for KHC benefits. This mandatory disclosure of the applicant's SSN is authorized by the Kidney Health Care Act, Chapter 42, Section 42.007, and KHC Rules, Section 61.4 (1)(D).

The SSN is needed to coordinate hospitalization and medical benefits between KHC and other third-party payors such as an insurance policy, individual health plan, group health plan, Title XVIII (Medicare) and/or Title XIX (Medicaid) under the Social Security Administration, Veteran's Administration benefits, state or municipal government public health programs, etc., as authorized by the KHC ACT, Sections 42.002 and 42.009., and KHC rules, Section 61.4

### Applicant Statement of Assurances

I have read this application and I understand its meaning. At the time of my signature, all the blanks were filled in. (If someone signs this application for the applicant, please explain why and the relationship to the applicant). I certify that:

1. All information presented herein may be released by Kidney Health Care (KHC) for verification purposes.
2. I give permission to the Bureau of Kidney Health Care to communicate with and release information to appropriate agencies, organizations, physicians and other health professionals on my behalf.
3. This information will be held confidential and will ultimately be used for my benefit.

4. By assigning my KHC benefits to providers, I authorize them to receive reimbursement from KHC on my behalf.

5. I have been informed of or have read the Kidney Health Care rules and know that they are available for review at my facility and I have had an opportunity to ask questions about the rules.

I understand that this application is a legal document and that by signing it under oath before a Notary Public I am stating that, to the best of my knowledge, all statements made on the KHC application are true and correct. I also understand that if I have made false statements, this may be a crime punishable under the laws of the State of Texas.

### PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.tdh.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

### Applicant Signature

X \_\_\_\_\_  
 (If applicant is a minor or under legal guardianship, the above signature line is for the parent, managing conservator of legal guardian.)

\_\_\_\_\_  
Date

### Notary Information

Subscribed and sworn to before me on this, the \_\_\_\_\_ day of \_\_\_\_\_, to certify which witness my hand and official seal of office.

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Print Name

Notary Public in and for

\_\_\_\_\_  
County/Parish

\_\_\_\_\_  
State

\_\_\_\_\_  
Commission Expires

Seal/Stamp